FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044057

Facility Name: SALEM VILLAGE NURSING

Address: 1314 ROWELL AVE (Number) JOLIET (City) 60433 (Zip Code)

County: WILL

Telephone Number: (815) 727-5451 **Fax #** (815) 727-9413

IDPA ID Number: 431823694001

Date of Initial License for Current Owners: 08/31/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3	204	Intermediate (ICF)	204	74,460	3
4		Intermediate/DD			4
5	6	Sheltered Care (SC)	6	2,190	5
6		ICF/DD 16 or Less			6
7	272	TOTALS	272	99,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,330	80	12,542	16,952	8
9	SNF/PED					9
10	ICF	41,537	13,385	1,029	55,951	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	45,867	13,465	13,571	72,903	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.43%

D. How many bed-hold days during this year were paid by Public Aid?
430 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/31/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/31/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 11,470

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	361,754	26,203	17,656	405,613		405,613		405,613			1
2	Food Purchase		438,228		438,228		438,228	(800)	437,428			2
3	Housekeeping	264,442	45,147		309,589		309,589		309,589			3
4	Laundry	95,478	25,504		120,982		120,982		120,982			4
5	Heat and Other Utilities			214,233	214,233		214,233		214,233			5
6	Maintenance	124,629	10,872	213,541	349,042		349,042	(49,415)	299,627			6
7	Other (specify):*											7
8	**TOTAL General Services**	846,303	545,954	445,430	1,837,687		1,837,687	(50,215)	1,787,472			8
	B. Health Care and Programs											
9	Medical Director			27,400	27,400		27,400	(2,000)	25,400			9
10	Nursing and Medical Records	2,987,804	260,038	211,846	3,459,688		3,459,688	16,121	3,475,809			10
10a	Therapy	75,298	195,102	8,661	279,061		279,061		279,061			10a
11	Activities	215,405	14,022	1,706	231,133		231,133		231,133			11
12	Social Services	107,637		4,400	112,037		112,037		112,037			12
13	Nurse Aide Training											13
14	Program Transportation			6,137	6,137		6,137		6,137			14
15	Other (specify):*							3,745	3,745			15
16	**TOTAL Health Care and Programs**	3,386,144	469,162	260,150	4,115,456		4,115,456	17,866	4,133,322			16
	C. General Administration											
17	Administrative	185,143		416,000	601,143		601,143	(133,918)	467,225			17
18	Directors Fees											18
19	Professional Services			195,487	195,487		195,487	6,124	201,611			19
20	Dues, Fees, Subscriptions & Promotions			87,968	87,968		87,968	(53,998)	33,970			20
21	Clerical & General Office Expenses	167,126	28,528	137,728	333,382		333,382	80,197	413,579			21
22	Employee Benefits & Payroll Taxes			758,627	758,627		758,627		758,627			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,651	3,651		3,651	876	4,527			24
25	Other Admin. Staff Transportation			24,131	24,131		24,131	7,602	31,733			25
26	Insurance-Prop.Liab.Malpractice			214,941	214,941		214,941	640	215,581			26
27	Other (specify):*							28,120	28,120			27
28	**TOTAL General Administration**	352,269	28,528	1,838,533	2,219,330		2,219,330	(64,357)	2,154,973			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,584,716	1,043,644	2,544,113	8,172,473		8,172,473	(96,706)	8,075,767			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SALEM VILLAGE NURSING #0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			110,466	110,466		110,466	453,281	563,747			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			67,562	67,562		67,562	523,497	591,059			32
33	Real Estate Taxes			101,015	101,015		101,015	33	101,048			33
34	Rent-Facility & Grounds			1,080,000	1,080,000		1,080,000	(1,066,391)	13,609			34
35	Rent-Equipment & Vehicles			49,378	49,378		49,378	(11,697)	37,681			35
36	Other (specify):*											36
37	TOTAL Ownership			1,408,421	1,408,421		1,408,421	(101,277)	1,307,144			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,220,236		1,220,236		1,220,236		1,220,236			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			171	171		171	(171)				41
42	Provider Participation Fee			145,635	145,635		145,635		145,635			42
43	Other (specify):*			3,517	3,517		3,517	(3,517)				43
44	TOTAL Special Cost Centers		1,220,236	149,323	1,369,559		1,369,559	(3,688)	1,365,871			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,584,716	2,263,880	4,101,857	10,950,453		10,950,453	(201,670)	10,748,783			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	156,575	30		9
10	Interest and Other Investment Income	(29)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(800)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(29,161)	21		18
19	Entertainment	(11,122)	20		19
20	Contributions	(1,350)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(37,773)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(951)	20		28
29	Other-Attach Schedule	(84,946)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (9,557)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(192,114)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (192,114)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (201,670)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

SALEM VILLAGE NURSING

ID# 0044057

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charge	$ (1,845)	21	1
2	Public Relations	(3,041)	20	2
3	Theft	(135)	21	3
4	IL Cope	(250)	20	4
5	Marketing	(3,517)	43	5
6	PPA-Medical Director	(2,000)	09	6
7	Cable Expense	(7,465)	06	7
8	Vending Expense	(171)	41	8
9	Misc Income	(912)	21	9
10	Bank Charge-Building	(436)	21	10
11	Finance charge	(4,020)	32	11
12	Non-allowable Car Rental	(10,459)	35	12
13	Direct TV	(6,614)	35	13
14	PPA- Legal	(1,845)	19	14
15	Prior period legal	(286)	19	15
16	Capitalized R&M	(41,950)	06	16
17				17
18				18
19				19
20				20
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99				99
100				100
101	Total	(84,946)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(800)											(800)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(49,415)											(49,415)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(50,215)											(50,215)	8
	B. Health Care and Programs													
9	Medical Director	(2,000)											(2,000)	9
10	Nursing and Medical Records			16,121									16,121	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,745									3,745	15
16	**TOTAL Health Care and Programs**	(2,000)		19,866									17,866	16
	C. General Administration													
17	Administrative			(133,918)									(133,918)	17
18	Directors Fees													18
19	Professional Services	(2,131)		8,255									6,124	19
20	Fees, Subscriptions & Promotions	(54,487)		489									(53,998)	20
21	Clerical & General Office Expenses	(32,489)	436	112,250									80,197	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			876									876	24
25	Other Admin. Staff Transportation			7,602									7,602	25
26	Insurance-Prop.Liab.Malpractice			640									640	26
27	Other (specify):*			28,120									28,120	27
28	**TOTAL General Administration**	(89,107)	436	24,314									(64,357)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(141,322)	436	44,180									(96,706)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	156,575	295,404	1,302									453,281	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,049)	526,787	759									523,497	32
33	Real Estate Taxes			33									33	33
34	Rent-Facility & Grounds		(1,080,000)	13,609									(1,066,391)	34
35	Rent-Equipment & Vehicles	(17,073)		5,376									(11,697)	35
36	Other (specify):*													36
37	TOTAL Ownership	135,453	(257,809)	21,079									(101,277)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(171)											(171)	41
42	Provider Participation Fee													42
43	Other (specify):*	(3,517)											(3,517)	43
44	TOTAL Special Cost Centers	(3,688)											(3,688)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(9,557)	(257,373)	65,259									(201,670)	45

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				SALEM VILLAGE		BUILDING
				PROPERTIES	JOLIET	PARTNERSHIP

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental	$ 1,080,000	SALEM VILLAGE PROPERTIES	100.00%	$	$ (1,080,000)	1
2	V								2
3	V	32	Interest Expense		SALEM VILLAGE PROPERTIES	100.00%	526,787	526,787	3
4	V	21	Bank Charge		SALEM VILLAGE PROPERTIES	100.00%	436	436	4
5	V	30	Depreciation		SALEM VILLAGE PROPERTIES	100.00%	295,404	295,404	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,080,000			$ 822,627	$ * (257,373)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSE CONSULTANT	$	HEALTHCARE MNGMNT. ASSOC.	100.00%	$ 16,121	$ 16,121	15
16	V	15	HEALTH CARE EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	3,745	3,745	16
17	V	17	ADMIN. SAL.-NON OWNER		HEALTHCARE MNGMNT. ASSOC.	100.00%	59,388	59,388	17
18	V	19	PROFESSIONAL FEES		HEALTHCARE MNGMNT. ASSOC.	100.00%	8,255	8,255	18
19	V	20	DUES, SUBSCRIPTIONS		HEALTHCARE MNGMNT. ASSOC.	100.00%	489	489	19
20	V	21	CLERICAL & GENERAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	73,254	73,254	20
21	V	24	SEMINAR		HEALTHCARE MNGMNT. ASSOC.	100.00%	876	876	21
22	V	25	TRAVEL		HEALTHCARE MNGMNT. ASSOC.	100.00%	7,602	7,602	22
23	V	26	INSURANCE		HEALTHCARE MNGMNT. ASSOC.	100.00%	640	640	23
24	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	19,207	19,207	24
25	V	30	DEPRECIATION		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,302	1,302	25
26	V	34	OFFICE SPACE		HEALTHCARE MNGMNT. ASSOC.	100.00%	13,609	13,609	26
27	V	32	INTEREST		HEALTHCARE MNGMNT. ASSOC.	100.00%	759	759	27
28	V	33	REAL ESTATE TAXES		HEALTHCARE MNGMNT. ASSOC.	100.00%	33	33	28
29	V	35	EQUIPMENT RENTAL		HEALTHCARE MNGMNT. ASSOC.	100.00%	5,376	5,376	29
30	V	21	CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	14,285	14,285	30
31	V	27	EMP. BEN. GEN. & ADMIN.		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,582	1,582	31
32	V	21	CLERICAL SALARIES		HEALTHCARE MNGMNT. ASSOC.	100.00%	24,711	24,711	32
33	V	27	EMPLOYEE BENEFITS		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,776	2,776	33
34	V	17	ADMIN. SALARY - M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	19,225	19,225	34
35	V	17	ADMIN. SALARY - D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	23,469	23,469	35
36	V	27	EMP. BEN.-M. SUISSA		HEALTHCARE MNGMNT. ASSOC.	100.00%	1,918	1,918	36
37	V	27	EMP. BEN.-D. ARYEH		HEALTHCARE MNGMNT. ASSOC.	100.00%	2,637	2,637	37
38	V	17	MANAGEMENT FEE	236,000	HEALTHCARE MNGMNT. ASSOC.	100.00%		(236,000)	38
39	Total			$ 236,000			$ 301,259	$ * 65,259	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ERIC ROTHNER	RELATIVE	ADMIN	0	SEE ATTACHED	0.98	1.36%	MGT FEE	$ 60,000	17-3	1
2	MARK SUISSA	OWNER	ADMIN	45.00%	SEE ATTACHED	24.87	41.45%	MGT FEE	60,000	17-3	2
3	MARK SUISSA	OWNER	ADMIN	45.00%	SEE ATTACHED	24.87	41.45%	ALLOC.HCMA	19,225	17-7	3
4	DAVID ARYEH	OWNER	ADMIN	5.00%	SEE ATTACHED	15.34	21.31%	MGT FEE	60,000	17-3	4
5	DAVID ARYEH	OWNER	ADMIN	5.00%	SEE ATTACHED	15.34	21.31%	ALLOC.HCMA	23,469	17-7	5
6	LORRAINE SUISSA	OWNER	ADMIN	45.00%		20	100.00%	SALARY	35,006	17-1	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 257,700		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HEALTHCARE MNGMNT. ASSOC.
Street Address: 1401 S. BRENTWOOD BOULEVARD
City / State / Zip Code: BRENTWOOD, MO. 63144
Phone Number: (314) 963-7570
Fax Number: (314) 963-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSE CONSULTANT	ILL. & MO. PAT. DAYS	291,047	6	$ 63,981	$ 63,981	73,333	$ 16,121	1
2	15	HEALTH CARE EMPLOYEE BE	ILL. & MO. PAT. DAYS	291,047	6	14,862		73,333	3,745	2
3	17	ADMIN. SAL.-NON OWNER	ILL. & MO. PAT. DAYS	291,047	6	235,701	235,701	73,333	59,388	3
4	19	PROFESSIONAL FEES	ILL. & MO. PAT. DAYS	291,047	6	32,764		73,333	8,255	4
5	20	DUES, SUBSCRIPTIONS	ILL. & MO. PAT. DAYS	291,047	6	1,941		73,333	489	5
6	21	CLERICAL & GENERAL	ILL. & MO. PAT. DAYS	291,047	6	290,735	211,448	73,333	73,254	6
7	24	SEMINAR	ILL. & MO. PAT. DAYS	291,047	6	3,475		73,333	876	7
8	25	TRAVEL	ILL. & MO. PAT. DAYS	291,047	6	30,170		73,333	7,602	8
9	26	INSURANCE	ILL. & MO. PAT. DAYS	291,047	6	2,542		73,333	640	9
10	27	EMPLOYEE BENEFITS	ILL. & MO. PAT. DAYS	291,047	6	76,229		73,333	19,207	10
11	30	DEPRECIATION	ILL. & MO. PAT. DAYS	291,047	6	5,169		73,333	1,302	11
12	34	OFFICE SPACE	ILL. & MO. PAT. DAYS	291,047	6	54,010		73,333	13,609	12
13	32	INTEREST	ILL. & MO. PAT. DAYS	291,047	6	3,011		73,333	759	13
14	33	REAL ESTATE TAXES	ILL. & MO. PAT. DAYS	291,047	6	131		73,333	33	14
15	35	EQUIPMENT RENTAL	ILL. & MO. PAT. DAYS	291,047	6	21,338	34,464	73,333	5,376	15
16	21	CLERICAL SALARIES	ILL. PAT. DAYS	176,918	4	34,464		73,333	14,285	16
17	27	EMP. BEN. GEN. & ADMIN.	ILL. PAT. DAYS	176,918	4	3,816		73,333	1,582	17
18	21	CLERICAL SALARIES	DIRECT		1	24,711	24,711		24,711	18
19	27	EMPLOYEE BENEFITS	DIRECT		1	2,776			2,776	19
20	17	ADMIN. SALARY - M. SUISSA	AVG. HOURS WORKED	60	6	46,381	46,381	25	19,225	20
21	17	ADMIN. SALARY - D. ARYEH	AVG. HOURS WORKED	37	4	56,621	56,621	15	23,469	21
22	27	EMP. BEN.-M. SUISSA	AVG. HOURS WORKED	60	6	4,626		25	1,918	22
23	27	EMP. BEN.-D. ARYEH	AVG. HOURS WORKED	37	4	6,361		15	2,637	23
24										24
25	TOTALS					$ 1,015,815	$ 673,306		$ 301,259	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	AMERICAN NATL BANK		X	MORTGAGE	$62,203.00	08/01/98	$ 7,840,000	$ 6,996,601	08/31/05	7.30%	$ 526,787	1
2												2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN NATL BANK		X	LINE OF CREDIT				630,000			31,244	6
7	ADMINISTAR FEDERAL		X								5,934	7
8												8
9	TOTAL Facility Related				$62,203.00		$ 7,840,000	$ 7,626,601			$ 563,965	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										27,094	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 27,094	14
15	TOTALS (line 9+line14)						$ 7,840,000	$ 7,626,601			$ 591,059	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income	X					$	$			$ (29)	1
2	Due to Member	X		WORKING CAPITAL							26,364	2
3	ALLOC. HMA		X								759	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 27,094	21

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	103,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	101,048	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,952)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	103,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	101,048	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999	91,910	10
2000	96,786	11
2001	101,015	12

2002 ACCRUAL IS $101,015*1.02=103,305

ALLOCATION R/E TAX HMA $33

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SALEM VILLAGE NURSING COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT STEVE LAVANDA

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-23-304-007-0000	LONG TERM CARE PROPERTY	$ 136.28	$ 136.28
2.	30-07-23-304-011-0000	LONG TERM CARE PROPERTY	$ 100,420.02	$ 100,420.02
3.	30-07-23-304-010-0000	LONG TERM CARE PROPERTY	$ 458.72	$ 458.72
4.	ALLOCATION FROM HMA		$	$ 33.00
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 101,015.02	$ 101,048.02

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SALEM VILLAGE NURSING COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0044057

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 127,847 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1998	$ 408,000	1
2					2
3	TOTALS			$ 408,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1998	108,515		20	5,427	5,427	22,821	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		8,021,280	205,674		401,064	195,390	1,737,944	68
69	Financial Statement Depreciation			10,502			(10,502)		69
70	TOTAL (lines 4 thru 69)		$ 8,129,795	$ 216,176		$ 406,491	$ 190,315	$ 1,760,765	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,129,795	$ 216,176		$ 406,491	$ 190,315	$ 1,760,765	1
2	FIRE ALARM REPAIRS	1999	663		20	33	33	132	2
3	PAINT & WALLPAPER	1999	29,300		20	1,465	1,465	5,860	3
4	MOTORS & FUSES	1999	1,100		20	55	55	220	4
5	ELECTRICAL WORK	1999	1,192		20	60	60	240	5
6	CARPET	1999	502		20	25	25	98	6
7	COVE BASES	1999	2,003		20	100	100	392	7
8	FIRE ALARM REPAIRS	1999	546		20	27	27	106	8
9	ECONOCARE	1999	981		20	49	49	192	9
10	CARPET	1999	1,258		20	63	63	242	10
11	CARPET	1999	1,632		20	82	82	314	11
12	CARPET	1999	1,926		20	96	96	368	12
13	PAINTING	1999	1,125		20	56	56	215	13
14	WALLPAPER	1999	700		20	35	35	134	14
15	WALLPAPER	1999	1,952		20	98	98	376	15
16	DRYWALL INSTALLATION	1999	4,000		20	200	200	767	16
17	PAINTING	1999	2,315		20	116	116	445	17
18	DOOR HINGES &CLOSER	1999	930		20	47	47	176	18
19	DOOR CLOSERS	1999	700		20	35	35	131	19
20	ITEMS TO FIX HOLES	1999	1,262		20	63	63	236	20
21	WALLPAPER	1999	401		20	20	20	75	21
22	FILLING HOLES IN WAL	1999	548		20	27	27	101	22
23	MISC PAINTING & DECO	1999	313		20	16	16	60	23
24	COVE BASE	1999	310		20	16	16	61	24
25	CARPENTRY & REMODELI	1999	1,624		20	81	81	304	25
26	WALLPAPER	1999	981		20	49	49	192	26
27	MISC PAINTING & DECO	1999	343		20	17	17	64	27
28	WALLPAPER	1999	120		20	6	6	23	28
29	CARPENTRY &REMODELIN	1999	1,569		20	78	78	293	29
30	WALLPAPER	1999	167		20	8	8	30	30
31	FIRE DAMPERS	1999	58,800		20	2,940	2,940	11,025	31
32	BATHROOM REMODELING	1999	1,500		20	75	75	275	32
33	WALLPAPER	1999	2,561		20	128	128	469	33
34	TOTAL (lines 1 thru 33)		$ 8,253,119	$ 216,176		$ 412,657	$ 196,481	$ 1,784,381	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 8,253,119	$ 216,176		$ 412,657	$ 196,481	$ 1,784,381	1
2	FIRE ALARM	1999	15,647		20	782	782	2,933	2
3	WALLPAPER	1999	247		20	12	12	44	3
4	WALLPAPER	1999	2,444		20	122	122	447	4
5	WALLPAPER INSTALL	1999	9,868		20	493	493	1,890	5
6	TOILETS	1999	602		20	30	30	110	6
7	ELECTRICAL WORK	1999	942		20	47	47	172	7
8	PAGING SYSTEM	1999	649		20	32	32	117	8
9	PLUMBING	1999	2,350		20	118	118	433	9
10	CARPENTRY & REMODEL	1999	765		20	38	38	139	10
11	CARPENTRY & REMODEL	1999	2,300		20	115	115	422	11
12	MISC.PAINTING & DECO	1999	143		20	7	7	26	12
13	MISC.PAINTING & DECO	1999	346		20	17	17	62	13
14	EMERGENCY LIGHT	1999	613		20	31	31	114	14
15	LIGHT FIXTURES	1999	2,149		20	107	107	392	15
16	PAINTING AND DECOR	1999	860		20	43	43	158	16
17	HVAC REPAIRS	1999	1,177		20	59	59	216	17
18	SIGNAGE	1999	1,025		20	103	103	378	18
19	SIGNAGE	1999	851		20	85	85	305	19
20	SIGNAGE	1999	874		20	87	87	312	20
21	CARPET	1999	526		20	26	26	93	21
22	FIRE ALARM REPAIRS	1999	2,017		20	101	101	362	22
23	SENSORS	1999	613		20	31	31	111	23
24	A/C COMPRESSOR	1999	1,240		20	62	62	222	24
25	FIRE ALARM REPAIRS	1999	515		20	26	26	98	25
26	PAINTING	1999	708		20	35	35	125	26
27	MISC PAINTING & DECO	1999	514		20	26	26	95	27
28	DRYWALL SUPPLIES	1999	367		20	18	18	69	28
29	ELEVATOR REPAIRS	1999	954		20	48	48	172	29
30	DRYWALL AND PAINTING	1999	9,000		20	450	450	1,575	30
31	BATHROOM REMODELING	1999	517		20	26	26	91	31
32	ELECTRICAL WORK	1999	826		20	41	41	144	32
33	A/C MOTORS	1999	579		20	29	29	102	33
34	TOTAL (lines 1 thru 33)		$ 8,315,347	$ 216,176		$ 415,904	$ 199,728	$ 1,796,310	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 8,315,347	$ 216,176		$ 415,904	$ 199,728	$ 1,796,310	1
2	A/C PARTS	1999	662		20	33	33	118	2
3	A/C COMPRESSOR	1999	1,240		20	62	62	217	3
4	PLUMBING WORK	1999	1,271		20	64	64	224	4
5	CUBICLE CURTAINS	1999	851		20	43	43	151	5
6	WALLPAPER	1999	470		20	24	24	82	6
7	FLOOR WORK	1999	14,667		20	733	733	2,504	7
8	DECORATING	1999	1,700		20	85	85	290	8
9	COVE BASE	1999	437		20	22	22	75	9
10	DOOR HARDWARE	1999	861		20	43	43	147	10
11	A.C PARTS	1999	594		20	30	30	103	11
12	PAINTING	1999	1,119		20	56	56	191	12
13	INSTALL DRAIN	1999	6,672		20	334	334	1,113	13
14	PAINTING	1999	5,000		20	250	250	833	14
15	BRICK WORK	1999	2,542		20	127	127	423	15
16	WALLPAPER	1999	3,903		20	195	195	650	16
17	FLOOR TILE	1999	900		20	45	45	150	17
18	SEWER WORK	1999	1,249		20	62	62	207	18
19	PAINTING	1999	4,000		20	200	200	667	19
20	WALLPAPER	1999	(7,068)		20	(6,568)	(6,568)	(7,392)	20
21	PUMPS	1999	560		20	56	56	187	21
22	PAINTING	1999	630		20	32	32	107	22
23	PAINTING	1999	337		20	17	17	57	23
24	RAMP DOOR	1999	2,123		20	106	106	345	24
25	COVE BASES	1999	766		20	38	38	124	25
26	COVE BASES	1999	688		20	34	34	111	26
27	MISC.PAINTING & DECO	1999	895		20	45	45	146	27
28	TILE	1999	506		20	25	25	79	28
29	TILE & COVE BASE	1999	1,373		20	69	69	219	29
30	ELECTRICAL WORK	1999	665		20	33	33	107	30
31	PLUMBING WORK	1999	902		20	45	45	143	31
32	PAINT	1999	595		20	30	30	95	32
33	BLINDS	1999	680		20	34	34	108	33
34	TOTAL (lines 1 thru 33)		$ 8,367,137	$ 216,176		$ 412,308	$ 196,132	$ 1,798,891	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 8,367,137	$ 216,176		$ 412,308	$ 196,132	$ 1,798,891	1
2	MISC PAINT & DEC	1999	666		20	33	33	102	2
3	TILE	1999	1,011		20	51	51	157	3
4	CARPET	1999	408		20	20	20	62	4
5	LIGHT FIXTURES	1999	546		20	27	27	83	5
6	FLOOR TILE	1999	626		20	31	31	96	6
7	WALL COVERING	2000	332		20	17	17	48	7
8	WALLPAPER	2000	717		20	36	36	102	8
9	BORDER	2000	93		20	5	5	14	9
10	WALLCOVER	2000	1,271		20	64	64	176	10
11	WALL COVER	2000	301		20	15	15	41	11
12	BORDER	2000	172		20	9	9	24	12
13	WALLPAPER	2000	5,010		20	251	251	669	13
14	WALL COVERING	2000	1,361		20	68	68	176	14
15	BORDER	2000	2,129		20	106	106	274	15
16	BORDER	2000	108		20	5	5	13	16
17	BORDER	2000	65		20	3	3	8	17
18	BORDER	2000	340		20	17	17	43	18
19	WALLPAPER	2000	3,712		20	186	186	465	19
20	WALL COVERING	2000	6,155		20	308	308	744	20
21	BORDER	2000	2,058		20	103	103	249	21
22	WALL COVERING	2000	535		20	27	27	65	22
23	BORDER	2000	97		20	5	5	12	23
24	WALLCOVERING	2000	5,897		20	295	295	664	24
25	BORDER	2000	42		20	2	2	5	25
26	BORDER	2000	885		20	44	44	99	26
27	PAINTING	2000	41,550		20	2,078	2,078	4,502	27
28	VINYL FLOORING	2000	1,804		20	90	90	270	28
29	UNDERLAYMENT	2000	275		20	14	14	41	29
30	DRYWALL/WALLPAPER	2000	575		20	29	29	68	30
31	PAINT/WALLPAPER	2000	1,050		20	53	53	110	31
32	OLYMPIAN GENERATOR	2000	41,977		20	2,099	2,099	5,772	32
33	ELECTRICAL WORK	2000	21,545		20	1,077	1,077	2,782	33
34	TOTAL (lines 1 thru 33)		$ 8,510,450	$ 216,176		$ 419,476	$ 203,300	$ 1,816,827	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 8,510,450	$ 216,176		$ 419,476	$ 203,300	$ 1,816,827	1
2	DOORS	2000	1,162		20	58	58	164	2
3	CUBICLE CURTAINS	2000	7,325		20	366	366	1,933	3
4	CUBICLE CURTAINS	2000	7,735		20	387	387	1,602	4
5	CUBICLE CURTAINS	2000	8,390		20	420	420	1,743	5
6	WALL SCONCE, CHANDLE	2000	3,891		20	195	195	860	6
7	CUBICLE CURTAINS	2000	2,131		20	107	107	303	7
8	DRAPERIES	2000	553		20	28	28	61	8
9	WALLCOVERING	2000	7,972		20	399	399	1,130	9
10	PHONE SYSTEM	2000	13,987		20	699	699	1,631	10
11	HANDRAILS	2001	2,805		20	140	140	280	11
12	BASEBOARDS	2001	1,108		20	55	55	110	12
13	DRYWALL	2001	4,109		20	205	205	410	13
14	HANDRAILS	2001	8,502		20	425	425	850	14
15	WALLCOVERINGS	2001	10,640		20	532	532	1,020	15
16	DRYWALL	2001	1,825		20	91	91	174	16
17	HANDRAILS	2001	7,606		20	380	380	697	17
18	HANDRAILS	2001	13,970		20	699	699	1,107	18
19	HANDRAILS	2001	7,081		20	354	354	531	19
20	HANDRAILS	2001	6,670		20	334	334	418	20
21	FENCING	2001	8,200		20	410	410	444	21
22	ALARM SYSTEM	2001	1,468		20	73	73	116	22
23	ALARM SYSTEM	2001	4,250		20	213	213	337	23
24	HVAC REPAIRS	2001	5,283		20	264	264	484	24
25	FIRE ALARM REPAIR	2001			20				25
26	PLUMBING REPAIRS	2001	1,539		20	77	77	116	26
27	ELECTRICAL REPAIRS	2001	4,220		20	422	422	633	27
28	HEATER BOOSTER	2001	1,442		20	72	72	102	28
29	KITCHEN ELECTRICAL	2001	520		20	26	26	28	29
30	DOORS	2001	1,779		20	89	89	178	30
31	MAIL BOXES	2001	1,635		20	82	82	116	31
32	JANITOR SINK REPAIRS	2001	1,534		20	77	77	141	32
33	FIRE ALARM REPAIR	2001	2,395		20	120	120	180	33
34	TOTAL (lines 1 thru 33)		$ 8,662,177	$ 216,176		$ 427,275	$ 211,099	$ 1,834,726	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 8,662,177	$ 216,176		$ 427,275	$ 211,099	$ 1,834,726	1
2	PUMP REPAIRS	2001	950		20	48	48	72	2
3	WALK IN FREEZER RPR	2001	690		20	35	35	53	3
4	COOLER REPAIRS	2001	1,424		20	71	71	95	4
5	JANITOR'S SINK	2001	1,577		20	79	79	145	5
6	FIRE ALARM REPAIR	2001	502		20	25	25	38	6
7	BOILER PUMP	2001	950		20	48	48	72	7
8	WALK IN FREEZER	2001	690		20	35	35	53	8
9	WASHER REPAIRS	2001	996		20	50	50	75	9
10	COOLER REPAIRS	2001	1,424		20	71	71	95	10
11	ALARM REPAIRS	2001	855		20	43	43	57	11
12	PHONES	2001	3,385		20	169	169	338	12
13	PHONES	2001	3,247		20	162	162	270	13
14	BATHROOM VINYL FLOORING	2002	6,422		20	428	428	428	14
15	CONSTRUCTION OF WALL	2002	935		20	78	78	78	15
16	WATER HEATER	2002	7,000		20	486	486	486	16
17	KITCHEN WATER HEATER	2002	4,525		20	283	283	283	17
18	WINDOW INSTALLATION	2002	2,033		20	119	119	119	18
19	SAT-T-LOK SYSTEMS	2002	4,956		20	472	472	472	19
20	DURO-LAST ROOF	2002	34,750		20	2,606	2,606	2,606	20
21	REMODELING	2002	7,500		20	375	375	375	21
22	DRAIN LINE REPAIR	2002	1,274		20	117	117	117	22
23	BASEMENT REPAIR	2002	1,197		20	110	110	110	23
24	PLUMBING REPAIR	2002	1,376		20	126	126	126	24
25	REWIRE GARBADE DISPOSAL	2002	583		20	58	58	58	25
26	REMOVE DEBRIS	2002	1,500		20	138	138	138	26
27	HOT WATER REPAIR	2002	513		20	51	51	51	27
28	DOOR HINGES	2002	608		20	51	51	51	28
29	OAK STRP LAM	2002	1,752		20	131	131	131	29
30	TAC-COMPRESSOR	2002	1,204		20	80	80	80	30
31	SEAT LIFT	2002	622		20	41	41	41	31
32	MIRROR	2002	607		20	46	46	46	32
33	REFRIG REPAIR	2002	688		20	34	34	34	33
34	TOTAL (lines 1 thru 33)		$ 8,758,913	$ 216,176		$ 433,941	$ 217,765	$ 1,841,919	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 8,758,913	$ 216,176		$ 433,941	$ 217,765	$ 1,841,919	1
2	HOT WATER REPAIR	2002	525		20	26	26	26	2
3	TOILET	2002	758		20	32	32	32	3
4	CUSTOM DOOR	2002	904		20	38	38	38	4
5	SEAT LIFT	2002	568		20	19	19	19	5
6	TOILET	2002	696		20	70	70	70	6
7	CUSTOM DOOR	2002	603		20	20	20	20	7
8	WALK-IN-FREEZER	2002	645		20	48	48	48	8
9	FIXTURE WALL MOUNT	2002	1,027		20	34	34	34	9
10	BRACKET FIXTURE	2002	1,159		20	29	29	29	10
11	BRACKET FIXTURE	2002	636		20	16	16	16	11
12	BRACKET FIXTURE	2002	890		20	22	22	22	12
13	GAS VAVES	2002	1,089		20	18	18	18	13
14	FLOOR REPAIR	2002	520		20	9	9	9	14
15	CALL SYSTEM	2002	535		20	4	4	4	15
16	BRACKET FIXTURE	2002	3,145		20	26	26	26	16
17	REPAIR GENERATOR	2002	916		20	8	8	8	17
18	DRAIN LINE REPAIR	2002	1,252		20	52	52	52	18
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21									21
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,774,781	$ 216,176		$ 434,412	$ 218,236	$ 1,842,390	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 8,774,781	$ 216,176		$ 434,412	$ 218,236	$ 1,842,390	1
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,774,781	$ 216,176		$ 434,412	$ 218,236	$ 1,842,390	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 8,774,781	$ 216,176		$ 434,412	$ 218,236	$ 1,842,390	1
2									2
3									3
4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,774,781	$ 216,176		$ 434,412	$ 218,236	$ 1,842,390	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 8,774,781	$ 216,176		$ 434,412	$ 218,236	$ 1,842,390	1
2									2
3									3
4									4
5									5
6									6
7									7
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 8,774,781	$ 216,176		$ 434,412	$ 218,236	$ 1,842,390	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1998	1976	$ 8,021,280	$ 205,674	39	$ 401,064	$ 195,390	$ 1,737,944	4
5											5
6											6
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	Improvement Type**										
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35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
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66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,021,280	$ 205,674		$ 401,064	$ 195,390	$ 1,737,944	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,236,668	$ 155,049	$ 120,001	$ (35,048)	10	$ 502,378	71
72	Current Year Purchases	79,370	35,947	9,334	(26,613)	10	9,334	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,316,038	$ 190,996	$ 129,335	$ (61,661)		$ 511,712	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,498,820	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 407,172	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 563,747	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 156,575	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,354,102	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	ALLOC. HMA				13,609			6
7	TOTAL				$ 13,609 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 25,154 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2000 LEXUS	$	$ 6,411	17
18	ADMINISTRATIVE	2002 -CAMRY		6,116	18
19					19
20					20
21	TOTAL		$	$ 12,527	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING

STATE OF ILLINOIS
0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 02	hrs	$		$	$ 342,947		$ 342,947	1
2	Licensed Speech and Language Development Therapist	39 - 02	hrs				73,659		73,659	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 02	hrs				349,193		349,193	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				429,821		429,821	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						24,616		24,616	13
14	TOTAL			$		$	$ 1,220,236		$ 1,220,236	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 100,429	$ 100,429	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,478,763	1,478,763	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	287,824	287,824	6
7	Other Prepaid Expenses	1,928	1,928	7
8	Accounts Receivable (owners or related parties)	759,208	300,762	8
9	Other(specify): See Supplemental Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,628,152	$ 2,169,706	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		408,000	13
14	Buildings, at Historical Cost		8,021,280	14
15	Leasehold Improvements, at Historical Cost	620,202	620,202	15
16	Equipment, at Historical Cost	537,482	1,353,482	16
17	Accumulated Depreciation (book methods)	(447,737)	(2,071,645)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 709,947	$ 8,331,319	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,338,099	$ 10,501,025	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,227,942	$ 1,621,283	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	630,000	630,000	29
30	Accrued Salaries Payable	219,245	219,245	30
31	Accrued Taxes Payable (excluding real estate taxes)	21,289	21,289	31
32	Accrued Real Estate Taxes(Sch.IX-B)	103,000	103,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	80,010	80,010	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,281,486	$ 2,674,827	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,996,601	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,996,601	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,281,486	$ 9,671,428	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 56,613	$ 829,597	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,338,099	$ 10,501,025	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (171,040)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (171,040)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	227,653	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 227,653	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 56,613	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,399,828	1
2	Discounts and Allowances for all Levels	1,321,772	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,721,600	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	437,653	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 437,653	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,774	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,614	20
21	Other Medical Services	12,557	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 15,949	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	29	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 29	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,875	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,875	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,178,106	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,837,687	31
32	Health Care	4,115,456	32
33	General Administration	2,219,330	33
	B. Capital Expense		
34	Ownership	1,408,421	34
	C. Ancillary Expense		
35	Special Cost Centers	1,223,924	35
36	Provider Participation Fee	145,635	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,950,453	40
41	**Income before Income Taxes (line 30 minus line 40)****	227,653	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 227,653	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,346	2,346	$ 69,939	$ 29.81	1
2	Assistant Director of Nursing	4,112	4,112	138,921	33.79	2
3	Registered Nurses	41,462	41,462	1,120,338	27.02	3
4	Licensed Practical Nurses	20,103	20,103	425,582	21.17	4
5	Nurse Aides & Orderlies	117,248	117,248	1,188,101	10.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,355	11,355	75,298	6.63	8
9	Activity Director	8,097	8,097	111,172	13.73	9
10	Activity Assistants	14,238	14,238	104,233	7.32	10
11	Social Service Workers	7,072	7,072	107,637	15.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	41,665	41,665	361,754	8.68	15
16	Dishwashers					16
17	Maintenance Workers	9,549	9,549	124,629	13.05	17
18	Housekeepers	33,182	33,182	264,442	7.97	18
19	Laundry	12,782	12,782	95,478	7.47	19
20	Administrator	2,239	2,239	87,999	39.29	20
21	Assistant Administrator	4,296	4,296	97,144	22.61	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,267	14,267	167,126	11.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,094	4,094	44,923	10.97	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	348,106	348,106	$ 4,584,716 *	$ 13.17	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	408	$ 17,656	01-03	35
36	Medical Director	MONTHLY	27,400	09-03	36
37	Medical Records Consultant	MONTHLY	4,214	10-03	37
38	Nurse Consultant	72	5,366	10-03	38
39	Pharmacist Consultant	MONTHLY	4,488	10-03	39
40	Physical Therapy Consultant	52	2,783	10a-03	40
41	Occupational Therapy Consultant	97	5,111	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	33	1,706	11-03	44
45	Social Service Consultant	64	4,032	12-03	45
46	Other(specify)				46
47	REHAB CONSULTANT	13	766	10a-03	47
48	PSY-SOCIAL	7	369	12-03	48
49	TOTAL (lines 35 - 48)	744	$ 73,891		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	8,790	197,778	10-03	52
53	TOTAL (lines 50 - 52)	8,790	$ 197,778		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CARMELITA VALERA	ADMINISTRATOR	0	$ 87,999
KENNETH PALIWODA	ASSISTANT ADMIN	0	62,138
LORRAINE SUISSA	ADMINISTRATIVE	45	35,006
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 185,143

B. Administrative - Other

Description	Amount
HEALTHCARE MGNT-HOME OFFICE	$ 236,000
M. SUISSA- MANAGEMENT FEE	60,000
E. ROTHNER-MANAGEMENT FEE	60,000
D. ARYEH-MANAGEMENT FEE	60,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 416,000

C. Professional Services

Vendor/Payee	Type	Amount
FR & R	Accounting	$ 27,399
LAWRENCE SCHWARTZ	LEGAL	2,800
BKD	Accounting	1,287
PERSONNEL PLANNER	Unemployment	1,582
DUNE MORRIS	LEGAL	160,619
LOWENBAUM	LEGAL	1,541
FRANKEL, RUBIN, BOND & DUB	LEGAL	84
MEYER MAGENCE	LEGAL	175
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 195,487

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 126,047
Unemployment Compensation Insurance	42,168
FICA Taxes	342,236
Employee Health Insurance	232,852
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFIT	14,906
EE BENEFIT	419
TOTAL (agree to Schedule V, line 22, col.8)	$ 758,627

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,114
Health Care Worker Background Check	
(Indicate # of checks performed 208)	1,455
DUES AND SUBSCRIPTION	4,933
LICENSES	22,979
ADVERTISIN	37,772
YELLOW PAGE ADVERTISING	951
ALLOC. HMA DUES	34
ALLOC. LICENSES	455
Less: Public Relations Expense	( )
Non-allowable advertising	(37,773)
Yellow page advertising	(951)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,970

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,651
ALLOC. HMA	876
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,527

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SALEM VILLAGE NURSING # 0044057 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **974** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **145,635**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

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(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%LN1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees